STATE OF MICHIGAN

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX
Petitioner

v **File No. 120501-001**

Blue Cross Blue Shield of Michigan
Respondent

Issued and entered
this _28th_ day of September 2011
by R. Kevin Clinton
Commissioner

ORDER

I. PROCEDURAL BACKGROUND

On April 8, 2011, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*. The Commissioner reviewed the request and accepted it on April 15, 2011.

The Commissioner immediately notified Blue Cross Blue Shield of Michigan (BCBSM) of the external review and asked for the information it used to make its adverse determination. The Commissioner received BCBSM's response on April 28, 2011.

The issue in this external review can be decided by a contractual analysis. The contract that defines the Petitioner's health care benefits is BCBSM' *Flexible Blue II Individual Market Certificate* (the certificate). The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II. FACTUAL BACKGROUND

The Petitioner's coverage with BCBSM was effective on April 15, 2010. On May 24, 2010, he had a routine physical examination including laboratory tests. BCBSM denied coverage for this care, stating it was provided during the 90-day waiting period for preventive services.

The Petitioner appealed BCBSM's denial. BCBSM held a managerial-level conference and then issued a final adverse determination dated February 17, 2011, upholding its denial.

III. ISSUE

Is BCBSM required to cover the Petitioner's May 24, 2010, services?

IV. ANALYSIS

Petitioner's Argument

The Petitioner states he called BCBSM on May 13, 2010, because he was a new member and did not understand his policy. He further states BCBSM advised him that his coverage was in effect and that he could get an annual physical examination without any out-of-pocket cost. Relying on that information, he scheduled his annual physical examination for May 24, 2010. BCBSM subsequently denied coverage for the examination and tests because they were performed during a 90-day waiting period for preventive care services.

The Petitioner argues that BCBSM's customer service representative should have told him during the May 13 telephone call about the 90-day waiting period. He wants BCBSM to reimburse him the $596.13 that he paid for the examination and related laboratory tests.

BCBSM's Argument

BCBSM maintains its denial of coverage for the examination and laboratory tests because they were preventive care services performed with the first 90 days of the Petitioner's coverage. The certificate contains the following language (p. 1.6):

> Preventive care benefits will not be subject to the 180-day pre-existing condition waiting period. However, preventive care benefits, including screening mammography, are subject to a 90-day waiting period from the effective date of your coverage. This waiting period is **not** waived even with proof of prior creditable coverage.

Under this provision, no preventive care would be covered until 90 days after the date the Petitioner's coverage was effective, i.e., July 14, 2010.

BCBSM states its documentation of the May 13 telephone call (not recorded) shows that the Petitioner was given an overview of his benefits, including information about deductibles and copayments. BCBSM maintains there was no mention of waiting periods for either pre-existing conditions or preventive care services. BCBSM believes it is unfortunate that the Petitioner feels he was misled but that it must abide by the terms of the certificate and that the Petitioner's care was appropriately denied.

Commissioner's Review

The certificate language is clear: preventive care is not a benefit for the first 90 days after coverage is effective. There is no dispute that the Petitioner's May 24, 2010, routine physical examination and laboratory tests[1] were preventive care or that they were performed within that 90-day period and therefore are not covered.

The Petitioner believes that BCBSM gave him information over the telephone that led him to believe his preventive care would be covered. BCBSM disputes that contention. Under the Patient's Right to Independent Review Act (PRIRA), the Commissioner's role is limited to determining whether a health plan has properly administered health care benefits under the terms of the applicable insurance contract and state law. Resolution of the dispute described by Petitioner cannot be part of a PRIRA decision because the PRIRA process lacks the hearing procedures necessary to make findings of fact based on evidence such as oral statements. Moreover, under PRIRA, the Commissioner lacks the authority to order relief based on doctrines such as misrepresentation or promissory estoppel.

The Commissioner finds that BCBSM correctly applied the terms of the certificate when it denied coverage for the Petitioner's preventive care on May 24, 2010.

V. ORDER

Blue Cross Blue Shield of Michigan's February 17, 2011, final adverse determination is upheld. BCBSM is not required to provide coverage for the Petitioner's May 24, 2010, preventive services.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than 60 days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.

R. Kevin Clinton
Commissioner

1 Two laboratory tests performed during that period were not preventive care and were covered by BCBSM. However, the approved amounts for the tests were applied to the Petitioner's deductible.